THOUGHTS ON THE ACADEMIC CENTER IN THE 1980s*

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Despite some of my recent writings, I am basically an optimist. Thus, while I agree that academic medical centers and those who work within them are in for some very challenging and stressful times, I am uncomfortable in labelling it a crisis. Further, although some of my academic colleagues look more anxious than I would wish for them, they seem in general a robust and healthy lot. They are quick on their feet, adept at raiding The Robert Wood Johnson Foundation coffers, and filled with vigor and new ideas. Thus, I do not view them as an "endangered species." Medical academics possess, I believe, superior adaptive qualities. While they are rarely meek, and are thus unlikely to inherit the earth, I feel certain that they will get their adequate share of it!

There is, in my mind, however, no doubt but that we are entering a period of significantly constrained resources in this country—and here this nation is not alone. During this period many of our important social institutions will be competing for their share of a less rapidly expanding pool of monies available to carry out their missions. Academic health centers, because of their size and their dependence on public funds, will clearly feel the pinch. But it is worth stressing that it seems unlikely that most will receive fewer dollars than in the past, although for some this will be the case. It will mean that most will have to trim their rates of growth sharply after a period of unparalleled expansion. After becoming used to travelling 75 M.P.H., it is difficult to comply with a 55 M.P.H. speed limit, but it can

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be done. It is clear, however, that this period will require some significant adaptations by academic institutions and those who live in them and some different ways of viewing the world and conducting their business.

In recent years I have written my views on the problems facing academic medical centers—probably in more detail than many of you wish to know. A little more than two years ago I attempted to take a look at where academic medical centers were at that time, and my conclusions formed the centerpiece of a small book on American medicine.[1,2] In those writings I voiced my concerns about the increasingly adversarial atmosphere marring the relationship between academic medical centers and government and my unhappiness at seeing what had been such a mutually beneficial partnership begin to come apart. It was my thesis then—and I feel it even more today—that a number of unusual pressures on academic centers, many not of their own making, were contributing to a progressive standoff. It seemed to me that the unique interface of academic medical centers with the public, because of the central position they occupied in providing tertiary care to Americans, created many tensions; their enormous size and expense had made them subject to all the problems and regulations that beset big enterprises in modern society which were not easy for physician-scholars to handle. I felt that the increasing responsibilities for delivering medical services to massive numbers of people who often lacked the resources to pay for that care were diverting energies from research and seriously overtaxing their capacities and their finances.

I advanced the thesis that the failure of government and the private medical sector to settle their differences about responsibilities for medical care had led to the direction of much of the weight of restrictive government actions at academic centers, despite the fact that they are not the major purveyors of medical care in this country. All of these had, in my judgment, created severe stresses which threatened their role as the principal generators of new knowledge and the educators of new health professionals.

Last November I extended those remarks in the Alan Gregg Lecture before the Association of American Medical Colleges.[3] At that time I offered some tentative projections that indicated that we were entering a period of slow economic growth and that this would lead to significant reductions in new federal and state monies to support academic health centers. I worried about the increasing dependence of academic medical centers on private practice incomes to support their work, believing that this posed some very real hazards for them unless they planned carefully to

use these monies to support their teaching and research ventures and not just for faculty salaries.

At that time it seemed to me that if academic centers simply tried to continue with business as usual, they might find themselves unable to deliver on the exciting research promises of the next decade; that they could become too involved in income-generating subspecialty practice, could lose low income and minority students because of high tuition fees, and could find themselves squabbling with one another in inappropriate entrepreneurial efforts to keep their individual heads above water. Many heard me say these things, and clearly I added to the general atmosphere of alarm.

However, I did, at the same time and with enthusiasm, suggest that another scenario was quite possible if academic centers planned carefully for a more constrained future than we found possible during the breathless rush to bigness and complexity of the 1950s and 1960s. I indicated that I felt that schools which thoughtfully assessed the possible advantages of more stability, worked to define their most vital and critical pursuits, built to develop a commitment to common goals, and streamlined and reduced their operations in ways that both preserved and strengthened their basic mission could find this a period of exciting self-renewal.

I feel this yet more today. Since I made those remarks I have been impressed by the imaginative ways that certain academic centers are adapting to less bountiful times. In some, practice incomes are used to support more fully fundamental institutional goals—basic teaching and research. In some, faculty members have become more closely knit and wedded to common objectives. In some, sophisticated planning as to what to abandon so that new programs can emerge without additional costs are taking place. Certain schools (although to my sorrow too few of them) continue to take seriously their responsibilities for admitting more low-income and minority students, and have laid new plans for the special needs for educational and financial support required by these young men and women. Thus, although academic medical centers continue to be viewed by some as "large, slowly moving creatures which bleed profusely when hit,"[4] some are showing that they are capable of prompt and significant adaptations to new realities without massive blood loss.

So, do the 1980s look more encouraging for academic health centers than a year ago? The answer is yes, if more of them proceed along the paths I have indicated above; no, if they persist in feeling that more public monies

are their only salvation. So today let me update some of those projections and make some additional suggestions about the kinds of roles that academic health centers might play which could permit them to yet further adapt and in the process help the nation get moving again.*

A refinement of the economic projections made a year ago has simply reinforced the opinions voiced at that time.

First, all evidence suggests an indeterminate period of slow economic growth—perhaps the slowest in many decades. This will place enormous pressures on the health care sector to flatten or reduce planned expenditures.

Second, a period of continuing inflation which will become yet a more visible and troubling problem during the next several years.

Third, a probable slowdown in growth of decreased real personal income.

Last, and receiving considerable attention today, a flattening out or actual decline in America's work force productivity—long the pride of his nation.

Here, some are pointing fingers at the health care sector. A recent *New York Times* editorial states it this way:

> American productivity, the measure of output per manhour...has been declining at an annual rate of 2 percent during 1979. This decline dramatizes the nation's need for a sustained remedial program. Without growth, the United States will not be able to afford the changes it wants or needs.
> ...*efforts need to be made to slow the growth of the service industries, particularly health services.* Productivity in this sector is 40 percent lower than the national average.[5]

This perception, whether it is right or wrong, needs to be seriously addressed by academic health centers. It clearly shapes American attitudes, and public attitudes are often forerunners of changes in public national agendas.

During the early 1970s, concerns about such social issues as better health, medical research, or more doctors pushed issues of importance to

* Over the last 18 months the staff of The Robert Wood Johnson Foundation, aided by a number of consultants, have been engaged in analyzing projections to develop forecasts on what the 1980s portend for those working in health and medical care. The methodologies involved, the sources of the data, and its interpretation are presented in more extended form in the following publications:
Blendon, R.J., Schramm, C.J., Molone, T.W., and Rogers, D.E.: The 1980's: A period of stress of health institutions, *J.A.M.A.* In press.
Rogers, D.E., Aiken, L., and Blendon, R.J.: Personal Medical Care: Its Adaptation to the 1980's. Occasional paper, delivered October 15, 1980. Washington, D.C., The Institute of Medicine 1981.

academic institutions high on the national agenda for public and private action. However, today people are almost exclusively concerned with economic issues. Perhaps in part because of our successes in improving access to care, perhaps in part because of overpromising what biomedical research gains could mean for present generations, an impatient and worried public now lists high costs as the single most important problem in medicine facing Americans.

What then might be the posture of academic centers? What courses might they take to deal with these economic probabilities and shifts in attitudes? Clearly, as timeless institutions of enormous importance to us over the long haul, they must find ways to adapt that preserve their extraordinarily precious research and teaching functions. Evidence suggests that the American public recognizes and respects those missions. But they are asking that we try to continue them with reduced rates of escalation of the price tag.

That the number of young clinician investigators has declined alarmingly is clear. That there has been a startling drop in the number of medical students who wish to pursue academic careers is also all too evident. But in our desires to reverse this trend, we should look carefully for root causes of this desertion, rather than flailing out in ways that often tend to offend academe's supporters, both public and private.

Recently I have been disturbed by hearing or reading a whole series of oversimplistic statements attributed to distinguished academicians to explain this profound and worrisome drop in the number of young physicians opting for research careers.[6] As examples:

That the efforts of the last decade to deliver general medical care more equitably to all Americans has soured the public and medical students on research.

What nonsense! More than 90% of our graduates have always gone into practice. Efforts to prepare them more adequately for such careers and to think carefully about the social implications of what they do is not anti-academic or antiscience. Nor do I believe that concerns about patient care "sours" those who wish to contribute new knowledge to the system.

Another statement: That in our concern to increase the number of primary care doctors we have discouraged students with a serious scientific interest.

Again, I think that this is wide of the mark. Medical students continue to be selected on the basis of high scientific interests and aptitudes. Indeed, many feel that we have pushed the competition so hard in these areas that

we have distorted some young minds in the process. Further, to suggest that efforts to create more generalists is detrimental to biomedical science insults the intelligence of many of academe's supporters.

But most popular is that simply money—or lack of it—is the root of the problem. Again, I think it is hard to make this case stick. Further, it tends to externalize the whole problem and to lay all the blame on others. I would point out that those who made commitments to academic careers and research in the 1940s and 1950s—and who served as the role models for many of us—did so with the understanding that they would not make large incomes. Further, a recent study by Dr. Marvin Siperstein suggests that funds to support aspiring young physician-investigators and to support their initial research efforts are still available. Some are going wanting for lack of applicants.[7]

It is worth remembering that research funds were never easy to come by. It was then, and is even more so now, a tough, demanding, and competitive game. Thus, while we should continue to fight against the increasing restrictions on The National Institutes of Health and the shortsightedness of curtailing funds for research when, in the long run, new knowledge is the only way sensibly to reduce the costs of care, we need to put these concerns in a responsible context.

All of us should carefully consider Dr. Ludwig Eichna's recent assessment of a personal return to being a medical student for four years after a 30-year hiatus as a distinguished researcher-teacher-clinician in an academic medical center.[8] Whether one agrees or disagrees with his educational philosophy, simply the fact that he found it so unappealing should cause us to look very closely at what we profess and the signals we emote in our daily academic lives. The recent public indications that scientific data have occasionally been falsified or the work of others plagiarized by members of the academic community has not added lustre to our calling. Clearly, these are symptoms that all is not well in our own house and this is not lost on young aspiring physician-academicians. We need to put our own affairs in order.

But to return to my central point. While we should emphasize the absolutely essential importance of our teaching and research missions, unquestionably the overall costs of medical care and academic medical centers as institutions are most on the minds of Americans. And, because of the public's enormous concerns about their own personal economic welfare, their more altruistic instincts to allot yet more public and private funds for

our academic pursuits have been seriously blunted if not abandoned.

Thus, I have two suggestions about how we should approach the preservation of the academic enterprise which at first blush will appear paradoxical.

My first: Would it not be wise for academic centers to understand clearly those economic concerns of the public they serve, and to recognize that they, as the flagships, the opinion shapers, and the leaders of a service industry which is now our second largest, should offer to help to allay these concerns? If productivity, effectiveness, and efficiency are major national worries, can academic centers show by their actions that they recognize this and that they are willing to play their own role in improving the situation while at the same time continuing their vital and more timeless academic pursuits? I believe they can.

Despite the enormously rapid growth of the health care sector—from 1.6 million in 1946 to almost 7 million people in 1980—little attention has been directed at improving the output of this massive system. Academic centers might take the lead in efforts to test the benefits of the regionalization of specific high-cost clinical services, of converting underused actual hospital beds to other less costly uses better to manage long-term illnesses, or of developing new clinical approaches that would reduce patient days in the hospital. Working with public policy makers, they might speed experiments using new financial incentives to encourage more out-of-hospital care. Programs designed to increase the effectiveness and efficiency of hospital-based physician groups and thoughtful studies which might help to eliminate potentially obsolete or costly regulatory policies all seem to me areas in which academic health centers could make significant contributions.

My second suggestion regarding the focus of academic health centers also addresses an era which I foresee causing increasing social tension during the 1980s.

Although not generally recognized, the period we are now entering threatens the very real improvements in access to care made by our most vulnerable and historically most deprived citizens during the 1970s. These groups have traditionally looked to academic health centers for much of their care, and the expanding services of our teaching hospitals have been a major force in eliminating the gaps between blacks and whites and the poor and nonpoor in the availability of physician services for the less fortunate.

The record of the last decade in this regard is a proud one. Both blacks and the poor, each with higher burdens of illness than most of us, now get to

physicians at rates comparable with those who are white and well-to-do, and this seems more in line with their needs than in times past.

But many straws in the wind suggest that the hardships caused by reducing funds spent on health will fall most heavily on these groups so recently taken into the health care system. Indeed, there is evidence that this is already happening. It may interest you to know that within New York City about 180,000 *fewer* people receive Medicaid help to pay their medical bills than in 1975.[9] Dr. Clifton Gaus of Georgetown has data indicating that rollbacks are widespread and that the number of people with Medicaid cards has dropped by almost 3 million since 1976.[10]

At present, your hospitals and your physicians continue to care for these individuals at reduced fees and to absorb the costs. Thus, these disturbing trends have not yet received significant national attention. However, if reductions in public programs continue, the absorptive capacity of your hospitals will be exceeded, the problems and human misery which will result will be increasingly evident. Your academic pursuits will suffer in the process.

Clearly, academic centers, particularly those in large cities which deliver much of this care, could play a major "public defender" role in this arena. Few thoughtful people wish to solve our health care cost problems by simply disenfranchizing the poor and the helpless, but it may happen in this mindless way unless steps are taken to prevent it.

Again, this will demand a different mindset and focus for those who guide academic health centers. It will require the recognition that your centers are now the major providers of care and often the largest employers of unskilled lower income people in the areas where you reside. It will require development of sensible patient care priorities to bring the most effective care to these groups at the least possible cost. It will require the development of new yardsticks to measure the effectiveness of that care in functional terms, not gross vital statistics regarding life and death. How swiftly are your patients being returned to work or to school or to independent living? Which technologies pay off and which should be abandoned? Where should you join forces with others? Where should services be coopted—or abandoned because of costly duplication? Clearly, there is a crying need for more hard-nosed, pragmatic research and experimentation to streamline and to make academic center medical care more effective so that Draconian solutions to cost can be avoided. Academics are used to approaching unsolved problems in scientific and unsentimental ways. These problems now need your attention.

As I indicated, at first glance to suggest a focus on these areas may seem very wide of the mark of the traditional mission of academic health centers. However, I make these suggestions for a very specific reason. It is clear that the major progress of academic health centers was made during periods of significant economic growth and rising overall productivity. It seems quite unlikely that this kind of progress can continue unless we can return to that happy state. Simply to preserve the biomedical research base developed so painfully during the last 40 years and to continue the output of new health professionals for the future, I believe that academic health centers must accept the fact that as participating members of a larger society, they must find ways to be more responsive to these major national concerns if for no other reason than their own simple self-interests.

I emphatically do not mean by this that academic centers can or should shoulder the whole burden of containing health care costs or delivering all the services needed to those who remain underserved. Clearly, this is not the role of academe. Being responsive can mean many things. It can be selective, not total. In this instance, I believe it should mean that academic centers indicate by their actions a willingness to bring their special brains and talents and aptitudes to bear to help solve these larger problems of society.

Michael Sovern, the new president of Columbia University, addressed this issue so eloquently in his recent inaugural address that I quote him here.[11] "It has been said that if the troublesome problems that beset the world fail to respect the departmental lines drawn by the academic specialties, so much the worse for the problem." While indicating that this was hyperbole, he nevertheless went on to say:

> I do not urge... any lessening of scholarly rigor, any sacrifice of disciplined inquiry. I do urge a fresh review of what the questions should be, of whether we are narrowing inquiry to a point where sub-specialists speak only to each other, and *whether we are not unwittingly impeding that highest of scholarly achievements—the grand synthesis.*

And this leads me to my last point, first advanced more tentatively two years ago. I believe that academic centers must restructure their ways of managing and governing their activities so that they can more swiftly adapt to new circumstances and be more capable of that "grand synthesis" than in times past.

At that time I wrote:

> The governance of academic health centers has developed along university lines. It is often ad hoc and consists of a series of coalitions that shift depending on the

> issue. It subserves the individual aspirations of researchers or clinical faculty quite well, but it falters badly when the institution is grappling with priorities or long-range goals.[2]

And herein lies the problem today. Academic health centers have become huge multimillion dollar enterprises, and myriads of complex interactions with the federal government, municipalities, community action groups, labor unions, and the like will determine how they fare in the period to come. The current frictions we are witnessing between many teaching hospitals which are now in that world and struggling under enormous regulatory pressures and their parent institutions, which continue in the academic mode, are clear signals of trouble ahead.

I think that most academic centers realize that their size and their responsibilities now demand leadership and a structure for getting business done quite differently than that which served them well in the 1950s. Physicians, particularly academic physicians skilled in teaching, research, and patient care, are rarely experts at organization design or management or adept at understanding the subtleties of long range financial planning or city renewal, although there are some outstanding exceptions to this statement. But making changes which place individuals with such skills in position of responsibility and authority in the hallowed halls of academe will come hard. It has many elements of Mr. Thurow's *Zero-Sum Society* that block progress.[12] There is the general belief that bureaucrats will win and faculty will lose in making such a transition. But perhaps all can gain something if governance changes include the institution of certain checks and balances to keep the academic enterprise intact. If scientists are to have the freedom to pursue their intellectual tasks, if teachers are to teach, and clinicians are to take optimal care of patients, some autonomy must be surrendered for the common good of these precious institutions. Perhaps the question should be simply, "If you were now designing these institutions from scratch with the development of new knowledge and the nourishment of young minds for medicine of the future as basic objectives, how would you do it?" I think this could be an exciting and enriching exercise.

Academic centers need leaders with a broad view of the role of their institutions as powerful community and national resources. I believe that they should play their appropriate role in muting or solving their share of certain problems which so threaten the American people today. A number of institutions are moving in just such directions and they seem to be happy and productive places in which to work.

Thus, I see academic physicians and their institutions undergoing mutation helpful to their continuing survival. I do not believe that they will disappear like the whooping crane or the passenger pigeon. It is my belief that they will become leaner but stronger in adapting to these new times. Clearly, life will be different and less laissez faire than what we have recently enjoyed, but I convinced that it can be equally rewarding.

Let me leave you with an observation recently made by Dr. Walsh McDermott.[13] He notes that the fall of 1929 heralded the onset of the great depression. This has recently been brought to life for those of us who did not experience it in Caroline Bird's book on this period titled *The Invisible Scar.*[14] There she makes the point that between 1930 and 1940 there was no overall growth in our economy. Indeed, all but four of the top 10 manufacturing companies ended the decade with less assets than they started with.

But Dr. McDermott points out that it was during this decade that two of the greatest advances in biomedicine of all times occured. The discovery of antimicrobial drugs—the sulfonamides—and the discovery that nucleic acid, specifically DNA, was the stuff which transmitted our heredity. To his list I would add yet another—the unravelling of the etiology of pernicious anemia in 1929.

He ends this observation with a statement so moving and so much the message that I wish to transmit here that I will simply quote him directly: "For, and this is the message that those early days in the 1930's have deeply imprinted in me, we must recall that there was another time when we were poor—and we had our Camelot too."

While times will be tougher economically, I believe that the decade to come offers enormous opportunities for biomedical research programs and for academic medical centers as teachers in an arena of enormous human importance if they prepare for it wisely and thoughtfully.

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